

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6155

CERTIFICATE OF DEATH

Reg. Dist. No.

06151

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Sykesville, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>R.F.D. # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Amelia</u> Last <u>Abbott</u>		4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-78</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		9b. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS, OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James McClure</u>		14. MOTHER'S MAIDEN NAME <u>Amanda (?) Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Edna Lee - Daughter-in-law: Sykesville</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>290.0 Pernicious anemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that I attended the deceased from <u>5-22-54</u> , 19 <u>54</u> , to <u>6-11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-11</u> , 19 <u>57</u> , and that death occurred at <u>11:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. Mastin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Springfield State Hospital</u> <u>6-12-57</u>	
PHYSICIAN'S NAME (Type) <u>Morrell N. Mastin, M.D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Freedom</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Hight - Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-13-57</u>	24b. REGISTRAR'S SIGNATURE <u>C. Hanywell</u>

RECEIVED

JUN 17 1957

BUREAU V. 3.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6156 CERTIFICATE OF DEATH

Reg. Dist. No. 75

06152

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. LENGTH OF STAY IN 1b <u>3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rexus Franklin Bachman</u>		4. DATE OF DEATH <u>June 17</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/1887</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chalmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George H. Bachman</u>		14. MOTHER'S MAIDEN NAME <u>Olley Ben Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Elly Ruth Bachman Westminster #3</u>		Address <u>Westminster #3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic arthrop</u> DUE TO <u>30 years</u> (c) <u>725X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>725X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 16, 1957</u> to <u>June 17, 1957</u> that I last saw the deceased alive on <u>June 16, 1957</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George P. Ward</u> M.D.		DATE SIGNED <u>June 19/57</u>	
PHYSICIAN'S NAME (Type) <u>Harrover Pa</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6/20/57</u>		22b. NAME OF CEMETERY OR CREMATORY <u>St. Bartholomew's</u>	
22c. LOCATION (City, town, or county) (State) <u>Harrover Pa</u>		22d. REC'D BY REGISTRAR <u>P. R. L. York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fredrick Buckner</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. H. H. L. Lerner</u>	

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6157

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>6 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POOL ROAD</u>			d. STREET ADDRESS <u>WESTMINSTER RD #4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CARROLL</u> First <u>HANSON</u> Middle <u>BARNES</u> Last			4. DATE OF DEATH <u>June 8 1957</u> Month <u>8</u> Day <u>1957</u> Year		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 17, 1948</u> (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR CONGOLEUM-NATRON</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FINKS BURG, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>PERCY A. BARNES</u>			14. MOTHER'S MAIDEN NAME <u>SALLY KNOUSE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>131-07-6872</u>		17. INFORMANT <u>MRS. C. H. Barnes, Westminster, Md. RD #4</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	Month. Day. Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/8/57</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Home Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Finksburg, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>6-9-57</u>	24b. REGISTRAR'S SIGNATURE <u>Hannibal Miller</u>		

RECEIVED

RECEIVED

6158

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RD. 4</u>				d. STREET ADDRESS <u>RD 4</u>			
3. NAME OF DECEASED (Type or print) <u>LILLIAN</u> First <u>LEE</u> Middle <u>BAUERLINE</u> Last				4. DATE OF DEATH <u>JUNE 19</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 10-1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS TURFLE</u>				14. MOTHER'S MAIDEN NAME <u>ELVINA SIMMONSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>EDWARD C. BAUERLINE</u> Address <u>HAMPSTEAD MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Lymphatic Leukemia</u> <u>2040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>October 23</u> , 19 <u>53</u> , to <u>June 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>57</u> , and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>117 S. Main St. Hampstead Md.</u> DATE SIGNED <u>6/29/57</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				ADDRESS <u>HAMPSTEAD Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 22 / 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM. WESTMINSTER, MD.</u>		22d. LOCATION (City, town, or county) (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard Westminster Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 6-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

and Date

DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. S.

JUN 27 1957

RECEIVED

6159 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 3001-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Beziat</u> Last <u>Beziat</u>		4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 6-1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Hamilton Beziat</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>450.0</u>	
17. INFORMANT <u>Hospital Records- Springfield State Hosp.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-24-</u> <u>19 55</u> , to <u>6-22--</u> , <u>19 57</u> , that I last saw the deceased alive on <u>6-22</u> <u>19 57</u> , and that death occurred at <u>5-05M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>6-22-57</u> ACTUAL SIGNATURE <u>M. N. Mastin</u> M.D. <u>Sykesville, Maryland</u> PHYSICIAN'S NAME (Type) <u>M. N. Mastin M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 27, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto</u> <u>Ind</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		24a. REC'D BY REGISTRAR DATE <u>7/16/57</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Heers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. DATE OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESSES</p>		<p>15. SIGNATURE OF FUNERAL HOME</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF CHIEF CLERK</p>		<p>18. SIGNATURE OF ASSISTANT CLERK</p>		<p>19. SIGNATURE OF DEPUTY CLERK</p>		<p>20. SIGNATURE OF RECORDS CLERK</p>	

BUREAU V. S.

JUL 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Form 10-57

BUREAU V. 3

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06156

6161 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u>				c. LENGTH OF STAY IN 1b <u>30 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>- Route 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Luanna</u> Middle <u>Chaney</u> Last <u>Chaney</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>		IF UNDER 24 HRS. Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Valentine Hartman</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Ann Bost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Oliver Chaney</u> Address <u>Rt 2 - Mt. Airy, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7 years (more than)</u> DUE TO (c) <u>7 years (more than)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7 years (more than)</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>April 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 30</u> , 19 <u>57</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.				ADDRESS (Street, city or town, state) <u>Mt. Airy, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>				DATE SIGNED <u>June 11, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Coplar Springs</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waltz</u> ADDRESS <u>Winfield, Md.</u>				24a. REC'D BY REGISTRAR <u>Robert R. Hurvill</u>		24b. REGISTRAR'S SIGNATURE <u>June 15, 1957</u>	

BUREAU V. S.

JUN 18 1957

15. 16. 17.

6162

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 31			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yr. 3mo. 12da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1619 Thames Street			
3. NAME OF DECEASED (Type or print) First JOHN Middle Chmielewski Last CHMELESKI				4. DATE OF DEATH Month June Day 21 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-4-89	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman's Asst.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jacob			
14. MOTHER'S MAIDEN NAME Frances				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1911 0 1914			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Springfield State Hospital - Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis with hemiparesis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 week 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction - systemic syphilis and chronic alcoholism.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 491X			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 3-2 19 54 , to 6-21 19 57 , that I last saw the deceased alive on 6-20 19 57 , and that death occurred at 3:46A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6-21-57 ACTUAL SIGNATURE Martin Gross M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-57		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) 1300 Dundalk Ave, Balto, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber				ADDRESS 705 South Ann Street		24a. REC'D BY REGISTRAR DATE 6/25/57	
				24b. REGISTRAR'S SIGNATURE C. Harry Meyer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6163

CERTIFICATE OF DEATH

06158

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>40 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unknown</u> <u>Sykesville</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Clayton</u> Last <u>Clayton</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>71 (?)</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace L. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Nimmo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. H. Gardner</u> Address <u>Hartford Conn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia, Paranoid Type</u> <u>300.3</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/26</u> , 19 <u>16</u> , to <u>6/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>57</u> , and that death occurred at <u>6:28</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gertrud Souwenfeldt M.D. Springfield State Hospital Sykesville, Md.</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital Sykesville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Gertrud Souwenfeldt M.D. Springfield State Hospital Sykesville, Md.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u>		22d. LOCATION (City, town, or county) (State) <u>Mountain, Hartford, Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight, Sykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Blair</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

JUN 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6164 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06159

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Adams</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD & Westminster</u>	c. LENGTH OF STAY IN 1b <u>8 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD #2 East Berlin 75x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>WALTER LEE DEHAVEN</u>		4. DATE OF DEATH <u>June 29 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1889</u>
9. AGE (In years last birthday) <u>68 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Henry De Haven</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>196-18-735</u>	17. INFORMANT <u>W. De Haven</u> Address <u>RD #2 York Springs, Pa.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sainedoro Cemetery</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David G. Bankard Westminster</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Va.</u>	
24a. REC'D BY REGISTRAR <u>DATE 7-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
U161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

LOW STATE
HEALTH DEPT.

WILLIAM BOMB

BUREAU V. S.

JUL 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6165

CERTIFICATE OF DEATH

Reg. Dist. No.

06460

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural New Windsor</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 mo.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Walkersville</u>					
				d. STREET ADDRESS <u>10822</u>					
3. NAME OF DECEASED (Type or print) First <u>ABRAHAM</u> Middle <u>H</u> Last <u>DEER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1957</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 12, 1889</u>			
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>					
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>George N. Deer</u>				14. MOTHER'S MAIDEN NAME <u>Arabel Long</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mr. Edward N. Deer, New Windsor, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac dilatation</u> DUE TO <u>with pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>polymyositis et al.</u> (c) <u>unknown</u>								INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from <u>August 1, 1956</u> , to <u>June 3, 1957</u> , that I last saw the deceased alive on <u>June 3, 1957</u> , and that death occurred at <u>2:00 A.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>B. D. Thomas</u>				ADDRESS (Street, city or town, state) <u>Frederick Maryland</u>					
PHYSICIAN'S NAME (Type) <u>B. D. Thomas</u>				DATE SIGNED <u>6/4/57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodsboro Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>				ADDRESS <u>Walkersville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6 June 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Ersie E. Benedict</u>					

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]	
9. STREET ADDRESS [Faint text]		10. CITY [Faint text]		11. COUNTY [Faint text]		12. STATE [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. PLACE OF DEATH [Faint text]		16. CAUSE OF DEATH [Faint text]	
17. MEDICAL HISTORY [Faint text]		18. PRESENT ILLNESS [Faint text]		19. TREATMENT [Faint text]		20. PHYSICIAN'S SIGNATURE [Faint text]	
21. CORONER'S SIGNATURE [Faint text]		22. JURY SIGNATURE [Faint text]		23. COUNTY CLERK'S SIGNATURE [Faint text]		24. REGISTERED MEDICAL EXAMINER'S SIGNATURE [Faint text]	

BUREAU V. S.

JUN 7 1957

RECEIVED

6166 CERTIFICATE OF DEATH

Reg. Dist. No.

07393

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amedeo Middle DeSANTIS Last DeSANTIS				4. DATE OF DEATH Month June Day 30 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1886	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckman				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jerome DeSantis				14. MOTHER'S MAIDEN NAME Sominica DeSantis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) 1917 to 1919				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 430.0 DUE TO (b) Generalized arteriosclerosis Years (c) Bronchopneumonia Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. HEART							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease with psychotic reaction.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 10, 1957 , to June 30, 1957 , that I last saw the deceased alive on June 30, 1957 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/1/57							
ACTUAL SIGNATURE Agustin del Campo M.D.				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 5 1957		22c. NAME OF CEMETERY OR CREMATORY Dah Lawn Cem	
22d. LOCATION (City, town, or county) (State) Eastern ave Md							
23. FUNERAL DIRECTOR'S SIGNATURE WENDELL WHIPPLE				24a. REC'D BY REGISTRAR JUL 9 1957			
24b. REGISTRAR'S SIGNATURE C. Harry Kern							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6103

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
W. J. BROWN		M		45		JAN 15 1910		NEW YORK		NEW YORK		NEW YORK		NEW YORK	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
Clerk		Heart Disease		Natural		3 weeks		JUL 5 1957		NEW YORK		NEW YORK		NEW YORK	
Physician		Hospital		Home		Nursing Home		Date of Death		Place of Death		City		State	
Dr. J. D. Smith		St. John's Hospital		Home		St. John's Hospital		JUL 5 1957		NEW YORK		NEW YORK		NEW YORK	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Director		Signature of Burial Director		Signature of Cemetery Director		Signature of Interment Director	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUL 9 1957

RECEIVED

6167

CERTIFICATE OF DEATH

06161

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6mos. 8days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
3. NAME OF DECEASED (Type or print) First Dewey Middle Wharton Last DODSON		4. DATE OF DEATH Month June Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1898
9. AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY - Yuk	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Malachi Dodson		14. MOTHER'S MAIDEN NAME Leslie Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 139-03-8766	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis, left leg DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Hours Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 334X	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 17, 1956 , to June 25, 1957 , that I last saw the deceased alive on June 24, 1957 , and that death occurred at 5:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/25/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-27-57	22c. NAME OF CEMETERY OR CREMATORY Landon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc.		ADDRESS 1217 St Paul St	24a. REC'D BY REGISTRAR DATE 6/25/57
		24b. REGISTRAR'S SIGNATURE C. H. Weer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4-1-10

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DOCTOR	
13. SIGNATURE OF MINISTER		14. SIGNATURE OF BURIAL		15. SIGNATURE OF FUNERAL	
16. SIGNATURE OF INTERMENT		17. SIGNATURE OF CREMATION		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

JUN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6168 CERTIFICATE OF DEATH

Reg. Dist. No.

06168

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN IB 23yrs, 6mos, 23days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2110 West Mulberry Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Henry Last DOGGETT				4. DATE OF DEATH Month June Day 5 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 2, 1885	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Doggett				14. MOTHER'S MAIDEN NAME Rebecca De Haven			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningo-encephalitis, syphilitic 025X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 022X (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old pulmonary tuberculosis. General paresis.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to June 5, 1957 , that I last saw the deceased alive on June 5, 1957 , and that death occurred at 9:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/6/57							
ACTUAL SIGNATURE Agustin del Campo M.D.				DATE SIGNED 6/6/57			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 10, 1957		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Balt. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				ADDRESS Randallstown Md.		24a. REC'D BY REGISTRAR DATE 6/12/57	
				24b. REGISTRAR'S SIGNATURE C. Harry Hays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

JUN 12 1957

RECEIVED

6169

CERTIFICATE OF DEATH

Reg. Dist. No.

06163

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2mos. 2days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 201 Tollgate Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leo Middle Joseph Last DOWNEY		4. DATE OF DEATH Month June Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-B&S Railroad		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Paul Downey		14. MOTHER'S MAIDEN NAME Teresa Canty	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X (b) Bronchopneumonia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Years Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 17, 1957 , to June 19, 1957 , that I last saw the deceased alive on June 19, 1957 , and that death occurred at 9:59P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/20/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/24/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lenord Ruck ADDRESS Harford Rd. Baltimore		24a. REC'D BY REGISTRAR DATE 6/20/57	24b. REGISTRAR'S SIGNATURE C. Harry Weer

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 24 1957

RECEIVED

6153

CERTIFICATE OF DEATH

06164

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>135X BOARDING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN O. EYLER</u>				4. DATE OF DEATH <u>JUNE 12 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 2-1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN O. EYLER</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>M. C. KEMPER ST. FANNIE BEX WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.4</u> <u>cerebral thrombosis</u> DUE TO <u>valvular heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.0</u> DUE TO (b) <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>49</u> to <u>June 12</u> 19 <u>57</u> that I last saw the deceased alive on <u>June 12</u> 19 <u>57</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. Reese Wilkens</u> M.D.				ADDRESS (Street, city or town, state) <u>161 Kemper Westminister</u> DATE SIGNED <u>6/14/57</u>			
PHYSICIAN'S NAME (Type) <u>F. Reese Wilkens</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-14-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH & BETHEPEN</u>		22d. LOCATION (City, town, or county) (State) <u>POSTY RIDGE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>6-15-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint, illegible handwriting.

BUREAU V. S.

JUN 24 1957

RECEIVED

Handwritten notes and signatures at the bottom of the form, including the name "E. J. Wilson" and other illegible text.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Parroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Parroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldesburg</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11111111111111111111</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Eleanor Fluhart</u>				4. DATE OF DEATH <u>June 5 1896</u> Month <u>6</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5 1896</u> last birthday	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Mamie E. Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>744</u>		17. INFORMANT <u>Robert L. Fluhart, Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Sydney S. Katz</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6/29/57</u>			
EXAMINER'S NAME (Type) <u>SYDNEY S. KATZ</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-57</u>		22c. NAME OF CEMETERY OR INTERMENTARY <u>New Oakland</u>		22d. LOCATION (City, town, or county) (State) <u>Md. Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight, Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>6-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harty</u>	

RECEIVED

JUL 2 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06166

6171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Sykesville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01.4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>			d. STREET ADDRESS <u>4908 Stafford Street</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elias Tracy Freeland</u>			4. DATE OF DEATH Month Day Year <u>6 3 19 57</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-1864</u>		9. AGE (In years last birthday) yrs. <u>93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Duncan Freeland</u>			14. MOTHER'S MAIDEN NAME <u>Sue Tracy</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of colon and rectum</u> <u>452X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aneurysm and thrombotic occlusion of left hypo-gastric artery.</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with senile brain disease with psychotic reaction</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>reaction</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 17</u> , 19 <u>57</u> , to <u>June 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>57</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED					
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Springfield State Hospital</u>					
PHYSICIAN'S NAME (Type) <u>Ilse Kamm, M.D.</u> <u>Sykesville, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>June 6/57</u>		<u>New Market</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
<u>Austin E. Donovan</u>		<u>3818 Roland Ave</u>		DATE <u>6 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Harry Heaps</u>	

BUREAU V. S.

JUN 9 1967

RECEIVED

6172

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery 180	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 1556.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 12712 Lacy Drive	
3. NAME OF DECEASED (Type or print) First Hazel Middle Jennie Last Gelsleichter		4. DATE OF DEATH Month June Day 22 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-92
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Mitchell		14. MOTHER'S MAIDEN NAME Jeanie Wendall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 4-44	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with circulatory disturbances with psychotic reaction. Chronic subdural hematoma.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 450.0	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-5- 1956 , to 6-22- 1957 , that I last saw the deceased alive on 6-22- 1957 , and that death occurred at 8.20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 6-23-57			
ACTUAL SIGNATURE Agustin del Campo M.D.			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-25-57	22c. NAME OF CEMETERY OR CREMATORY Wardman	22d. LOCATION (City, town, or county) (State) Dallas, Tex.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		24a. REC'D BY REGISTRAR C. Harry Allen	
ADDRESS Sykesville, Md.		DATE 6-23-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		April 14, 1928		Jackson, Mississippi	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS	
April 4, 1968		Memphis, Tennessee		Firing of a firearm		Suicide		Gunshot wound to the chest		Several days	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	

BUREAU V. S.

RECEIVED

JUN 29 1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06168

6173

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berrett</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrow Point</u>			
c. LENGTH OF STAY IN 1b <u>4 Mos.</u>				d. STREET ADDRESS <u>911 D. St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Singer Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Mae</u> Last <u>GILBERT</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 18, 1870</u>		9. AGE (In years last birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ymk</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Cover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Kenneth L. Gilbert</u> Address <u>26 York City</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancerous cachexia</u> DUE TO (c) <u>Bilateral carcinoma of breasts</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 years</u> <u>9 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis 450.0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 26</u> , 1957, to <u>June 7</u> , 1957, that I last saw the deceased alive on <u>June 6</u> , 1957, and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bertrand R. Gau</u>				ADDRESS (Street, city or town, state) <u>57 Central Avenue</u>		DATE SIGNED <u>6-7-57</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand R. GAU</u>				<u>SYKESVILLE Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-10-57</u>		<u>London Park</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				ADDRESS <u>Crydenville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-8-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6174

CERTIFICATE OF DEATH

061694

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yrs. 8mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hosp.				d. STREET ADDRESS 2012 St. Paul St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Anna Kingsnorth Harper				4. DATE OF DEATH Month Day Year 6 14 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown Approx 86	
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec.-clerk				10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Pierson				14. MOTHER'S MAIDEN NAME Virginia Kingsnorth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ----				16. SOCIAL SECURITY NO. ----		17. INFORMANT Address Hospital records - Springfield State Hosp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Arrested pulmonary Tuberculosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- 19 p. m. ---				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----	
20f. (City or town) (County) (State) ----							
21. I certify that I attended the deceased from 12-182 , 1953 , to 6-14- , 1957 , that I last saw the deceased alive on 6-14- , 1957 , and that death occurred at 11:00M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 6/14/57			
ACTUAL SIGNATURE M. N. Mastin				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) M. N. Mastin, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/15/57		22c. NAME OF CEMETERY OR CREMATORY BALTO CEM.		22d. LOCATION (City, town, or county) (State) BALTO CITY	
23. FUNERAL DIRECTOR'S SIGNATURE Knechtel & Son - Greermond & 22nd				24. REC'D BY REGISTRAR JUN 17 1957		24b. REGISTRAR'S SIGNATURE C. Harry Hear	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF SECOND WITNESS [Illegible]	
13. SIGNATURE OF THIRD WITNESS [Illegible]		14. SIGNATURE OF FOURTH WITNESS [Illegible]		15. SIGNATURE OF FIFTH WITNESS [Illegible]	
16. SIGNATURE OF SIXTH WITNESS [Illegible]		17. SIGNATURE OF SEVENTH WITNESS [Illegible]		18. SIGNATURE OF EIGHTH WITNESS [Illegible]	
19. SIGNATURE OF NINTH WITNESS [Illegible]		20. SIGNATURE OF TENTH WITNESS [Illegible]		21. SIGNATURE OF ELEVENTH WITNESS [Illegible]	
22. SIGNATURE OF TWELFTH WITNESS [Illegible]		23. SIGNATURE OF THIRTEENTH WITNESS [Illegible]		24. SIGNATURE OF FOURTEENTH WITNESS [Illegible]	
25. SIGNATURE OF FIFTEENTH WITNESS [Illegible]		26. SIGNATURE OF SIXTEENTH WITNESS [Illegible]		27. SIGNATURE OF SEVENTEENTH WITNESS [Illegible]	
28. SIGNATURE OF EIGHTEENTH WITNESS [Illegible]		29. SIGNATURE OF NINETEENTH WITNESS [Illegible]		30. SIGNATURE OF TWENTIETH WITNESS [Illegible]	
31. SIGNATURE OF TWENTY-FIRST WITNESS [Illegible]		32. SIGNATURE OF TWENTY-SECOND WITNESS [Illegible]		33. SIGNATURE OF TWENTY-THIRD WITNESS [Illegible]	
34. SIGNATURE OF TWENTY-FOURTH WITNESS [Illegible]		35. SIGNATURE OF TWENTY-FIFTH WITNESS [Illegible]		36. SIGNATURE OF TWENTY-SIXTH WITNESS [Illegible]	
37. SIGNATURE OF TWENTY-SEVENTH WITNESS [Illegible]		38. SIGNATURE OF TWENTY-EIGHTH WITNESS [Illegible]		39. SIGNATURE OF TWENTY-NINTH WITNESS [Illegible]	
40. SIGNATURE OF THIRTIETH WITNESS [Illegible]		41. SIGNATURE OF THIRTY-FIRST WITNESS [Illegible]		42. SIGNATURE OF THIRTY-SECOND WITNESS [Illegible]	
43. SIGNATURE OF THIRTY-THIRD WITNESS [Illegible]		44. SIGNATURE OF THIRTY-FOURTH WITNESS [Illegible]		45. SIGNATURE OF THIRTY-FIFTH WITNESS [Illegible]	
46. SIGNATURE OF THIRTY-SIXTH WITNESS [Illegible]		47. SIGNATURE OF THIRTY-SEVENTH WITNESS [Illegible]		48. SIGNATURE OF THIRTY-EIGHTH WITNESS [Illegible]	
49. SIGNATURE OF THIRTY-NINTH WITNESS [Illegible]		50. SIGNATURE OF FORTY WITNESS [Illegible]		51. SIGNATURE OF FORTY-FIRST WITNESS [Illegible]	
52. SIGNATURE OF FORTY-SECOND WITNESS [Illegible]		53. SIGNATURE OF FORTY-THIRD WITNESS [Illegible]		54. SIGNATURE OF FORTY-FOURTH WITNESS [Illegible]	
55. SIGNATURE OF FORTY-FIFTH WITNESS [Illegible]		56. SIGNATURE OF FORTY-SIXTH WITNESS [Illegible]		57. SIGNATURE OF FORTY-SEVENTH WITNESS [Illegible]	
58. SIGNATURE OF FORTY-EIGHTH WITNESS [Illegible]		59. SIGNATURE OF FORTY-NINTH WITNESS [Illegible]		60. SIGNATURE OF FIFTY WITNESS [Illegible]	

BUREAU V. 3

JUN 17 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06170

6175

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Detour</u>		LENGTH OF STAY (in this place) <u>25 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Detour</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Florida T.</u>		(Middle)		(Last) <u>Haugh</u>		(Year) <u>1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 27, 1870</u>	
9. AGE last birthday <u>86</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
13. FATHER'S NAME <u>James W. Troxell</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Zacharias</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Horatio I. Redding Detour, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>4200 Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>20 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>450.0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 15, 1941</u> , to <u>June 24, 1957</u> , that I last saw the deceased alive on <u>June 24, 1957</u> , and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. D. McVaugh</u>				DATE SIGNED <u>6/24/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-27-57</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Haugh's Cem.</u>		LOCATION (City, town, or county) (State) <u>Nr. Ladiesburg Md.</u>	
24. REC'D BY REGISTRAR <u>JUN 27 1957</u>		REGISTRAR'S SIGNATURE <u>R. H. Redding</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>			
				ADDRESS <u>Thurmont, Md.</u>			

CERTIFICATE OF DEATH

1957

Page One of Two

NAME OF DECEASED CARROLL, JAMES A.		SEX Male		RACE White	
DATE OF BIRTH May 15, 1920		PLACE OF BIRTH Baltimore, Md.		US BIRTH REGISTRATION NO. 1-1-1-1-1-1	
DATE OF DEATH May 27, 1957		PLACE OF DEATH Baltimore, Md.		US DEATH REGISTRATION NO. 1-1-1-1-1-1	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Coronary Thrombosis		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF CORONER J. Edgar Hoover		SIGNATURE OF REGISTRAR J. Edgar Hoover	

BUREAU V. S.

JUN 27 1957

RECEIVED

RECEIVED

6176

CERTIFICATE OF DEATH

Reg. Dist. No.

06171

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6 mos, 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 530 South Newkirk ST.	
3. NAME OF DECEASED (Type or print) First Middle Last Paul Wilhelm HERDA		4. DATE OF DEATH Month Day Year June 7, 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 9, 1877
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ERNEST HERDA		14. MOTHER'S MAIDEN NAME AMELIA WENINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes unknown		16. SOCIAL SECURITY NO. 014-005-4616	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction 334X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 4, 1956 , to June 7, 1957 , that I last saw the deceased alive on June 7, 1957 , and that death occurred at 1:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 6/7/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-10-57	22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.	22d. LOCATION (City, town, or county) (State) 3310 TAYLOR AVE. BALTO. CO., MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler		ADDRESS 901 S. CONKLING ST. BALTO., MD.	
24a. REC'D BY REGISTRAR DATE 6/10/57		24b. REGISTRAR'S SIGNATURE C. Harry Keene	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The text is mirrored and difficult to read.

BUREAU V. 2

JUN 11 1957

RECEIVED

6177

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Louis Last HILEY				4. DATE OF DEATH Month June Day 2 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1896	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hiley				14. MOTHER'S MAIDEN NAME Anna Reppe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung with metastasis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 2 years +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 301.1 Psychotic depression						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 27, 1957 , to June 2, 1957 , that I last saw the deceased alive on June 1, 1957 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED Walther H. Sonnenfeldt							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				PHYSICIAN'S NAME (Type) Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/5/57		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery Balto., Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. Christine Brudzinski				ADDRESS 1407 Eastern Ave		24a. REC'D BY REGISTRAR DATE JUN 5 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Keays			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6175

Form with multiple sections for death certificate data, including fields for name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

JUN 5 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06173

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mariottsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Mariottsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Arthur Hobbs</i>		4. DATE OF DEATH <i>June 5 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 31, 1895</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Stone Quarry</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William M. Hobbs</i>		14. MOTHER'S MAIDEN NAME <i>Hattie Arrington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unk.</i>		16. SOCIAL SECURITY NO. <i>unk.</i>	
17. INFORMANT <i>Walter Hobbs - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Burned to death -</i> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>Minute</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Burned in house which was destroyed by fire</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>7 4/5 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Mariottsville Carroll Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/7/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Springfield</i>		22d. LOCATION (City, town, or county) (State) <i>Sykesville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight - Sykesville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>6/6/57</i>	
24b. REGISTRAR'S SIGNATURE <i>C. H. H. H.</i>		DATE SIGNED <i>6/5/57</i>	

STATE OF MARYLAND, DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

JUN 01 1967

RECEIVED

77

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariottsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariottsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Linda A. Hobbs</u>		4. DATE OF DEATH <u>June 5 1957</u>	
5. SEX <u>sf.</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 18, 1946</u>	
9. AGE (In years last birthday) <u>10</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Arthur Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>Killie Mae Hellman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Walter Hobbs, Sykesville, md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burned to death</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in house which was destroyed by fire</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 5 1957</u> Hour a. m. <u>7</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Mariottsville</u> (County) <u>Carroll</u> (State) <u>md.</u>	
21. I certify that I attended the deceased from <u>June 5, 1957</u> to <u>June 5, 1957</u> , that I last saw the deceased alive on <u>June 5, 1957</u> , and that death occurred at <u>6:57</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>1 Sykesville, md.</u>	
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>6/5/57</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-7-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Knight</u>		24a. REC'D BY REGISTRAR <u>C. Harry Weaver</u>	
ADDRESS <u>Sykesville, md.</u>		DATE <u>6-6-57</u>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 10 1957

RECEIVED

6154

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>6 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>46 LIBERTY ST.</u>				d. STREET ADDRESS <u>46 LIBERTY ST.</u>			
3. NAME OF DECEASED (Type or print) <u>SAMUEL HARVEY HOFFMAN</u>				4. DATE OF DEATH <u>JUNE 18 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1874</u>		9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO., MD.</u>	
13. FATHER'S NAME <u>THEODORE H. HOFFMAN</u>				14. MOTHER'S MAIDEN NAME <u>LOUISA SNOOK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____			
17. INFORMANT <u>MRS. EARL LOVELL</u>				Address <u>46 LIBERTY ST. WESTMINSTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V. DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>YEARS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19 <u>50</u> , to <u>6-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/18/57</u> , 19_____, and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6/19/57</u>							
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.				PHYSICIAN'S NAME (Type) <u>JAMES J. MARSH</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL, NEW WINDSOR, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.S. Meyer, Jr.</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 6-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is faint and mostly illegible.

BUREAU V. S.

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6180

CERTIFICATE OF DEATH

0617681

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alexander Nursing Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>V.</u> Last <u>Kesselring</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 19, 1879</u>	
9. AGE (In years last birthday) <u>78 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob Bankert</u>				14. MOTHER'S MAIDEN NAME <u>Francis Bankard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Charles Rohrbaugh, Taneytown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breasts</u> <u>170 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June -</u> , 19 <u>56</u> , to <u>June 27, 1957</u> , that I last saw the deceased alive on <u>June 27, 1957</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge</u> DATE SIGNED <u>6-28-57</u>			
PHYSICIAN'S NAME (Type) <u>T. H. LEGG M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mervyn C. Fuss</u> ADDRESS <u>Mervyn C. Fuss Taneytown, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUL 1 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Lashie Zapp</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF SHERIFF		SIGNATURE OF DEPUTY SHERIFF	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF DEPARTMENT CLERK	

RECEIVED
JUL 1 1957
BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6181

CERTIFICATE OF DEATH

0617780

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR RURAL				c. LENGTH OF STAY IN 1b YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MAUDE MELVINA LAMBERT				4. DATE OF DEATH JUNE 7 1957			
5. SEX W		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/3/1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOHN P MOORE				14. MOTHER'S MAIDEN NAME AMELIA GOSNELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT ARTHUR LAMBERT				Address RURAL NEW WINDSOR MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis (Senile) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Semility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) South Main Street				20g. (County) Union Bridge, Maryland		20h. (State) MD	
21. I certify that I attended the deceased from April 8, 1957 , to June 7, 1957 , that I last saw the deceased alive on June 7, 1957 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. H. Legg				DATE SIGNED 6-8-57			
PHYSICIAN'S NAME (Type) Dr. T.H. Legg				ADDRESS (Street, city or town, state) Union Bridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/10/57		22c. NAME OF CEMETERY OR CREMATORY PIPE CREEK		22d. LOCATION (City, town, or county) (State) CARROLL CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hartzler				ADDRESS South Union Bridge		24a. REC'D BY REGISTRAR JUN 12 1957	
24b. REGISTRAR'S SIGNATURE Ernie Benedict							

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES E. HOGAN		AGE 45		SEX Male		RACE White		DATE OF BIRTH 1/15/1912		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK		SIGNATURE OF CLERK	

BUREAU V. S.

JUN 12 1957

RECEIVED

6182

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R WESTMINSTER MD	
c. LENGTH OF STAY IN 1b 18 YRS		d. STREET ADDRESS 70 CHARLES ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 70 CHARLES ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA E. MAGRUDER		4. DATE OF DEATH JUNE 13 1957	
5. SEX F	6. COLOR OR RACE GLOR	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 29-1884
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NOT KNOWN		14. MOTHER'S MAIDEN NAME ISABELLE MURDOCK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-92604	
17. INFORMANT MISS MELVA MAGRUDER		Address 70 CHARLES WESTMINSTER, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis & (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1955 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 13, 1957 to June 13, 1957 , that I last saw the deceased alive on June 13, 1957 , and that death occurred at 7/4/57 , from the causes and on the date stated above.			
ACTUAL SIGNATURE Margaret Speicher		ADDRESS (Street, city or town, state) Westminster Md	
PHYSICIAN'S NAME (Type) David A. Bankard		DATE SIGNED 6/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JUNE 16-1957	22c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY	22d. LOCATION (City, town, or county) (State) FRED. CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE David A. Bankard		ADDRESS WESTMINSTER MD	
24a. REC'D BY REGISTRAR DATE 6-15-57		24b. REGISTRAR'S SIGNATURE Samuel Miller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through.

BUREAU V. 3

JUN 17 1957

RECEIVED

6183

CERTIFICATE OF DEATH

06179

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 19yrs. 1mos. 6days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 4109 Doris Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Garland		First Garland Middle McCALL Last		4. DATE OF DEATH Month June Day 17 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1909		9. AGE (In years last birthday) 47	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew McCall				14. MOTHER'S MAIDEN NAME Clara George			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalitis, type not yet defined 491X DUE TO (Unknown) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Bronchopneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Unknown Days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic Psychosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 19 50, to June 17, 19 57, that I last saw the deceased alive on June 17, 19 57, and that death occurred at 11:50P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 6/18/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF June 20 1957		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City, town, or county) (State) Balto., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harry Jenkins				ADDRESS Ans Co 4905 York Rd		24a. REC'D BY REGISTRAR JUN 20 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Key			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove garbage papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6133

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. S.

JUN 20 1957

RECEIVED

6184

CERTIFICATE OF DEATH

06180

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2yr, 6mo, 17dy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Boonsboro/ Fahrney/Keedy Memorial Home			
3. NAME OF DECEASED (Type or print) First Joseph Middle W. Last McPHERSON				4. DATE OF DEATH Month June Day 13 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1872		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tom McPherson				14. MOTHER'S MAIDEN NAME Lucille - -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Usk		17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.0 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. Pulmonary tuberculosis.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 26, 19 54 , to June 13, 19 57 , that I last saw the deceased alive on June 12, 19 57 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/13/57			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-15-57	22c. NAME OF CEMETERY OR CREMATORY Boonsboro		22d. LOCATION (City, town, or county) Boonsboro		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown Md.				24a. REC'D BY REGISTRAR 6-15-57		24b. REGISTRAR'S SIGNATURE E. H. H. H. H.	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE - 18

BUREAU V. 3

JUN 18 1957

RECEIVED

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CLERGYMAN		17. SIGNATURE OF JUDGE		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE		22. SIGNATURE OF SHERIFF		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF SHERIFF		26. SIGNATURE OF SHERIFF		27. SIGNATURE OF SHERIFF		28. SIGNATURE OF SHERIFF		29. SIGNATURE OF SHERIFF		30. SIGNATURE OF SHERIFF	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6185

CERTIFICATE OF DEATH

06181

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 569 Moore Street			
3. NAME OF DECEASED (Type or print) First Columbus Middle Medley Last Medley				4. DATE OF DEATH Month 6 Day 3 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-2-1885	9. AGE (In years lost birthday) yrs. 71	IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carrier		10b. KIND OF BUSINESS OR INDUSTRY 5 & 10 Store		11. BIRTHPLACE (State or foreign country) St. Mary's Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Lila Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Columbus Medley - Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous Meningitis; exfoliation dermatitis 010X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. —			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from 5-23- , 19 57 , to 6-3- , 19 57 , that I last saw the deceased alive on 6-3- , 19 57 , and that death occurred at 10:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 6-3-57 ACTUAL SIGNATURE T. F. Vestal M.D. Henryton, Maryland PHYSICIAN'S NAME (Type) T. F. Vestal, Superintendent Henryton State Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 6-6-57		22c. NAME OF CEMETERY OR CREMATORY Christians Mtn.		22d. LOCATION (City, town, or county) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Newby				ADDRESS 578 W. Biddle		24a. REC'D BY REGISTRAR DATE —	
24b. REGISTRAR'S SIGNATURE Albert R. Swankhouse							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>JUN 3 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. PLACE OF BIRTH <i>MASSACHUSETTS</i>	
10. OCCUPATION <i>CLERK</i>		11. EDUCATION <i>HIGH SCHOOL</i>		12. RELIGION <i>ROMAN CATHOLIC</i>	
13. MARITAL STATUS <i>MARRIED</i>		14. DATE OF MARRIAGE <i>1945</i>		15. NAME OF SPOUSE <i>MARY J. BROWN</i>	
16. NAME OF PHYSICIAN <i>DR. J. J. SMITH</i>		17. NAME OF HOSPITAL <i>ST. JOSEPH'S</i>		18. NAME OF NURSE <i>MRS. J. J. SMITH</i>	
19. NAME OF FUNERAL HOME <i>JOHN J. BROWN</i>		20. NAME OF CEMETERY <i>ST. JOSEPH'S</i>		21. NAME OF MINISTER <i>FR. J. J. SMITH</i>	
22. NAME OF BURIAL PLACE <i>ST. JOSEPH'S</i>		23. NAME OF INTERMENT <i>ST. JOSEPH'S</i>		24. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
25. NAME OF CREMATION <i>ST. JOSEPH'S</i>		26. NAME OF CREMATION <i>ST. JOSEPH'S</i>		27. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
28. NAME OF CREMATION <i>ST. JOSEPH'S</i>		29. NAME OF CREMATION <i>ST. JOSEPH'S</i>		30. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
31. NAME OF CREMATION <i>ST. JOSEPH'S</i>		32. NAME OF CREMATION <i>ST. JOSEPH'S</i>		33. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
34. NAME OF CREMATION <i>ST. JOSEPH'S</i>		35. NAME OF CREMATION <i>ST. JOSEPH'S</i>		36. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
37. NAME OF CREMATION <i>ST. JOSEPH'S</i>		38. NAME OF CREMATION <i>ST. JOSEPH'S</i>		39. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
40. NAME OF CREMATION <i>ST. JOSEPH'S</i>		41. NAME OF CREMATION <i>ST. JOSEPH'S</i>		42. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
43. NAME OF CREMATION <i>ST. JOSEPH'S</i>		44. NAME OF CREMATION <i>ST. JOSEPH'S</i>		45. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
46. NAME OF CREMATION <i>ST. JOSEPH'S</i>		47. NAME OF CREMATION <i>ST. JOSEPH'S</i>		48. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
49. NAME OF CREMATION <i>ST. JOSEPH'S</i>		50. NAME OF CREMATION <i>ST. JOSEPH'S</i>		51. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
52. NAME OF CREMATION <i>ST. JOSEPH'S</i>		53. NAME OF CREMATION <i>ST. JOSEPH'S</i>		54. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
55. NAME OF CREMATION <i>ST. JOSEPH'S</i>		56. NAME OF CREMATION <i>ST. JOSEPH'S</i>		57. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
58. NAME OF CREMATION <i>ST. JOSEPH'S</i>		59. NAME OF CREMATION <i>ST. JOSEPH'S</i>		60. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
61. NAME OF CREMATION <i>ST. JOSEPH'S</i>		62. NAME OF CREMATION <i>ST. JOSEPH'S</i>		63. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
64. NAME OF CREMATION <i>ST. JOSEPH'S</i>		65. NAME OF CREMATION <i>ST. JOSEPH'S</i>		66. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
67. NAME OF CREMATION <i>ST. JOSEPH'S</i>		68. NAME OF CREMATION <i>ST. JOSEPH'S</i>		69. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
70. NAME OF CREMATION <i>ST. JOSEPH'S</i>		71. NAME OF CREMATION <i>ST. JOSEPH'S</i>		72. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
73. NAME OF CREMATION <i>ST. JOSEPH'S</i>		74. NAME OF CREMATION <i>ST. JOSEPH'S</i>		75. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
76. NAME OF CREMATION <i>ST. JOSEPH'S</i>		77. NAME OF CREMATION <i>ST. JOSEPH'S</i>		78. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
79. NAME OF CREMATION <i>ST. JOSEPH'S</i>		80. NAME OF CREMATION <i>ST. JOSEPH'S</i>		81. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
82. NAME OF CREMATION <i>ST. JOSEPH'S</i>		83. NAME OF CREMATION <i>ST. JOSEPH'S</i>		84. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
85. NAME OF CREMATION <i>ST. JOSEPH'S</i>		86. NAME OF CREMATION <i>ST. JOSEPH'S</i>		87. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
88. NAME OF CREMATION <i>ST. JOSEPH'S</i>		89. NAME OF CREMATION <i>ST. JOSEPH'S</i>		90. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
91. NAME OF CREMATION <i>ST. JOSEPH'S</i>		92. NAME OF CREMATION <i>ST. JOSEPH'S</i>		93. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
94. NAME OF CREMATION <i>ST. JOSEPH'S</i>		95. NAME OF CREMATION <i>ST. JOSEPH'S</i>		96. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
97. NAME OF CREMATION <i>ST. JOSEPH'S</i>		98. NAME OF CREMATION <i>ST. JOSEPH'S</i>		99. NAME OF CREMATION <i>ST. JOSEPH'S</i>	
100. NAME OF CREMATION <i>ST. JOSEPH'S</i>		101. NAME OF CREMATION <i>ST. JOSEPH'S</i>		102. NAME OF CREMATION <i>ST. JOSEPH'S</i>	

RECEIVED
JUN 4 1957
BUREAU V. B.

6186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo, 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 3v01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 6115 Parkway Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Henry Last MILLER				4. DATE OF DEATH Month June Day 30 Year 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1867		9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Daniel Miller Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Miller				14. MOTHER'S MAIDEN NAME Sarah Zachara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-07-9690		17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis years DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 334x					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 24 , 19 57 to June 30 , 19 57 , that I last saw the deceased alive on June 30 , 19 57 , and that death occurred at 8:35P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 7/1/57							
ACTUAL SIGNATURE Agustin del Campo M.D.		PHYSICIAN'S NAME (Type) Agustin del Campo Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto				24a. REC'D BY REGISTRAR DATE JUL 5 1957		24b. REGISTRAR'S SIGNATURE C. Harry Weers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-104

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. PLACE OF BIRTH [Faint text]	
10. DATE OF BIRTH [Faint text]		11. SEX OF BIRTH [Faint text]		12. AGE AT BIRTH [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. PLACE OF DEATH [Faint text]	
16. CAUSE OF DEATH [Faint text]		17. MANNER OF DEATH [Faint text]		18. PLACE OF BIRTH [Faint text]	
19. DATE OF BIRTH [Faint text]		20. SEX OF BIRTH [Faint text]		21. AGE AT BIRTH [Faint text]	
22. DATE OF DEATH [Faint text]		23. TIME OF DEATH [Faint text]		24. PLACE OF DEATH [Faint text]	
25. CAUSE OF DEATH [Faint text]		26. MANNER OF DEATH [Faint text]		27. PLACE OF BIRTH [Faint text]	
28. DATE OF BIRTH [Faint text]		29. SEX OF BIRTH [Faint text]		30. AGE AT BIRTH [Faint text]	
31. DATE OF DEATH [Faint text]		32. TIME OF DEATH [Faint text]		33. PLACE OF DEATH [Faint text]	
34. CAUSE OF DEATH [Faint text]		35. MANNER OF DEATH [Faint text]		36. PLACE OF BIRTH [Faint text]	
37. DATE OF BIRTH [Faint text]		38. SEX OF BIRTH [Faint text]		39. AGE AT BIRTH [Faint text]	
40. DATE OF DEATH [Faint text]		41. TIME OF DEATH [Faint text]		42. PLACE OF DEATH [Faint text]	
43. CAUSE OF DEATH [Faint text]		44. MANNER OF DEATH [Faint text]		45. PLACE OF BIRTH [Faint text]	
46. DATE OF BIRTH [Faint text]		47. SEX OF BIRTH [Faint text]		48. AGE AT BIRTH [Faint text]	
49. DATE OF DEATH [Faint text]		50. TIME OF DEATH [Faint text]		51. PLACE OF DEATH [Faint text]	
52. CAUSE OF DEATH [Faint text]		53. MANNER OF DEATH [Faint text]		54. PLACE OF BIRTH [Faint text]	
55. DATE OF BIRTH [Faint text]		56. SEX OF BIRTH [Faint text]		57. AGE AT BIRTH [Faint text]	
58. DATE OF DEATH [Faint text]		59. TIME OF DEATH [Faint text]		60. PLACE OF DEATH [Faint text]	
61. CAUSE OF DEATH [Faint text]		62. MANNER OF DEATH [Faint text]		63. PLACE OF BIRTH [Faint text]	
64. DATE OF BIRTH [Faint text]		65. SEX OF BIRTH [Faint text]		66. AGE AT BIRTH [Faint text]	
67. DATE OF DEATH [Faint text]		68. TIME OF DEATH [Faint text]		69. PLACE OF DEATH [Faint text]	
70. CAUSE OF DEATH [Faint text]		71. MANNER OF DEATH [Faint text]		72. PLACE OF BIRTH [Faint text]	
73. DATE OF BIRTH [Faint text]		74. SEX OF BIRTH [Faint text]		75. AGE AT BIRTH [Faint text]	
76. DATE OF DEATH [Faint text]		77. TIME OF DEATH [Faint text]		78. PLACE OF DEATH [Faint text]	
79. CAUSE OF DEATH [Faint text]		80. MANNER OF DEATH [Faint text]		81. PLACE OF BIRTH [Faint text]	
82. DATE OF BIRTH [Faint text]		83. SEX OF BIRTH [Faint text]		84. AGE AT BIRTH [Faint text]	
85. DATE OF DEATH [Faint text]		86. TIME OF DEATH [Faint text]		87. PLACE OF DEATH [Faint text]	
88. CAUSE OF DEATH [Faint text]		89. MANNER OF DEATH [Faint text]		90. PLACE OF BIRTH [Faint text]	
91. DATE OF BIRTH [Faint text]		92. SEX OF BIRTH [Faint text]		93. AGE AT BIRTH [Faint text]	
94. DATE OF DEATH [Faint text]		95. TIME OF DEATH [Faint text]		96. PLACE OF DEATH [Faint text]	
97. CAUSE OF DEATH [Faint text]		98. MANNER OF DEATH [Faint text]		99. PLACE OF BIRTH [Faint text]	
100. DATE OF BIRTH [Faint text]		101. SEX OF BIRTH [Faint text]		102. AGE AT BIRTH [Faint text]	

BUREAU V. 8

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6187 CERTIFICATE OF DEATH

07325 74

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 15 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS (Frederick) (Rural) 10 x 2 2			
3. NAME OF DECEASED (Type or print) First Sarah Middle Catherine Last Poole				4. DATE OF DEATH Month 6 Day 30 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Benjamin Sherfey				14. MOTHER'S MAIDEN NAME Lavina Eyler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-01-0650		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 304X Manic depressive psychosis, depressive phase.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 8/17 , 19 42 , to 6/30 , 19 57 , that I last saw the deceased alive on 6/30 , 19 57 , and that death occurred at 10:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrud Sonnenfeldt M.D. Springfield State Hospital Sykesville Md.				ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville Md.			
PHYSICIAN'S NAME (Type) Gertrud Sonnenfeldt M.D. Springfield State Hospital Sykesville Md.				DATE SIGNED 6/30/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 8-57		22c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) FREDERICK, MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Telecon				ADDRESS New Market		24a. REC'D BY REGISTRAR DATE 15 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Shepp			

BUREAU V. S.

JUL 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6188

CERTIFICATE OF DEATH

06182

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 mos, 28 dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1512 North Gay Street	
3. NAME OF DECEASED (Type or print) First Middle Last Magdalena Matilda Hilmar PORTS		4. DATE OF DEATH Month Day Year June 23 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1883
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rudolph Hilmar		14. MOTHER'S MAIDEN NAME Matilda --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 29nk	
17. INFORMANT Address Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction. Diabetes Mellitus.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 260X	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 19 56 , to June 23, 19 57 , that I last saw the deceased alive on June 22, 19 57 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/24/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-28-57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc. ADDRESS 1217 N. Paul St. Balt.		24a. REC'D BY REGISTRAR DATE 6-24-57	24b. REGISTRAR'S SIGNATURE A. Harry Allen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 27 1957

RECEIVED

6189

CERTIFICATE OF DEATH

Reg. Dist. No.

06183
743

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yr.9mo.5days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Carleton Last RIPPE				4. DATE OF DEATH Month June Day 23 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-30-1897	
9. AGE (In years lost birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Iowa				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Kmte Rippe				14. MOTHER'S MAIDEN NAME Carry Rippe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No - LF				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Address Springfield State Hospital - Sykesville, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchopneumonia DUE TO (c) Mental Deficiency, severe, chronic brain syndrome with presenile brain disease, with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency, severe, chronic brain syndrome with presenile brain disease, with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 305X			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9-18 , 19 53 , to 6-23 , 19 57 , that I last saw the deceased alive on 6-23 , 19 57 , and that death occurred at 11:04P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin Gross				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 6-24-57							
PHYSICIAN'S NAME (Type) Martin Gross, M. D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6-25-57		22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Wane				ADDRESS		24a. REC'D BY REGISTRAR JUN 26 1957 24b. REGISTRAR'S SIGNATURE C. Harry Myers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. 100-10

BUREAU V. 3

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6190

CERTIFICATE OF DEATH

06184

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg, Md. c. LENGTH OF STAY IN 1b X/ Finksburg d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #1		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Finksburg d. STREET ADDRESS R.F.D. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle H. Last Roskelly		4. DATE OF DEATH Month June Day 10 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1882 9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sta. Engineer (Ret'd)		10b. KIND OF BUSINESS OR INDUSTRY Kramer Brothers	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Roskelly		14. MOTHER'S MAIDEN NAME Bessie Bowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-1517	
17. INFORMANT Mrs. Clara Wildman, Address Finksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 8 1/2 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) none (County) (State)	
21. I certify that I attended the deceased from 11-16-53 , 19____, to 6-10-57 , 19____, that I last saw the deceased alive on 6-10-57 , 19____, and that death occurred at 8:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd., Reisterstown, Md. DATE SIGNED 6-10-57			
ACTUAL SIGNATURE A. D. Caples		M.D. 6 Hanover Rd., Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-12-57	
22c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery		22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR JUN 12 1957 24b. REGISTRAR'S SIGNATURE Harriet Miller	

CERTIFICATE OF DEATH

Form with multiple sections for death certificate data, including fields for name, date, cause of death, and location. The text is mostly illegible due to blurriness.

BUREAU V. S.

JUN 12 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

06185

6191

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN Ib 2yrs. 6mos. 8days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
f. STREET ADDRESS 2919 St. Paul Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Appollonia Middle Margaret Last RUSSANOWSKA		4. DATE OF DEATH Month June Day 18, Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 30, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR: Months 71 Days 71 Hours 71 Min. 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Leonard Russanowski		14. MOTHER'S MAIDEN NAME Josephine Anzenaski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.11 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.11 DUE TO myocardial infarction (c) 420.11 DUE TO myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with circ. dist., with cerebral arteriosclerosis, with psychotic reaction, plus pulmonary tuberculosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 002X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 10, 19 54 , to June 18, 19 57 , that I last saw the deceased alive on June 18, 19 57 , and that death occurred at 1:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.		ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 6/18/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/21/57	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Lenord Luck		ADDRESS Harford Rd. Baltimore	
24a. REC'D BY REGISTRAR 6/19/57		24b. REGISTRAR'S SIGNATURE C. Harry Weir	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

JUN 24 1957

RECEIVED

6192

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>Since 7-3-30</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1513 Eastern Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Koppien</u> Middle <u>SCHASTNEY</u> Last <u>SCHASTNEY</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-1-89</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Youko Schastney</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1918-1919</u>		17. INFORMANT <u>Hospital Records of Springfield State Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>300.3 Schizophrenic reaction, paranoid type.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>7-3</u> , 19 <u>30</u> , to <u>June 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>57</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Martin Gross</u> M.D. <u>Springfield State Hospital</u>				DATE SIGNED <u>6-4-57</u>			
PHYSICIAN'S NAME (Type) <u>Martin Gross, M. D.</u>				ADDRESS <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 7 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>C. Harry Heers</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CAUSE OF SIGNATURE		MANNER OF SIGNATURE	

BUREAU V. S.

JUN 7 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6193

06187

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>New Windsor</u>		<u>1 week</u>		TOWN <u>XO</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>X</u>				<u>P.O. 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ida</u> (Middle) <u>Virginia</u> (Last) <u>Simmons</u>				(Month) <u>6</u> (Day) <u>16</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>W</u>	<u>Widowed</u>	<u>Dec 24-1877</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Hardy Co. Maryland</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Isaac Lambert</u>				<u>Mary Elizabeth Funk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
<u>no</u>				<u>Paul Delinger Union Bridge Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Cardio Vas. Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>many</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac De compensation</u>				<u>10 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>4-24-57</u>		<u>X</u>		<u>YES</u>		<u>NO</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>X</u>		<u>X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		<u>M.</u>		<u>X</u>			
22. I hereby certify that I attended the deceased from <u>6-13-57</u> 1957, to <u>6-19-57</u> 1957, that I last saw the deceased alive on <u>6-15-57</u> 1957, and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>J. C. Stone</u>		<u>121 E. Bechtel</u>		<u>6-18-57</u>			
M.D. <u>Medicine</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or County) (State)	
<u>Burial</u>		<u>6-19-57</u>		<u>New House Cemetery</u>		<u>Pigg</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>6/18/57</u>		<u>Lelia R. Repko</u>		<u>Raymond R. Wright</u>		<u>Union Bridge Md.</u>	

CERTIFICATE OF DEATH

Part One

Name of Deceased

Sex and Age

Place of Birth

Place of Death

Time of Death

Day of Death

Year of Death

By Medical Examination

By Medical Examination

By Medical Examination

By Medical Examination

By Medical Examination

By Medical Examination

By Medical Examination

By Medical Examination

By Medical Examination

BUREAU Y. N.

JUN 20 1957

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NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT OF
 RECORDING DEATHS AND ISSUING CERTIFICATES OF DEATH
 THIS FORM IS TO BE FILLED OUT BY THE REGISTRAR OF DEATHS
 AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS
 UNTIL THE CERTIFICATE OF DEATH IS ISSUED TO THE NEXT OF KIN
 OR TO THE PERSON TO WHOM THE BODY IS TO BE DELIVERED
 AFTER WHICH IT IS TO BE DESTROYED

6194

CERTIFICATE OF DEATH

06188

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 14 X 22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS Piney Neck			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Clarence Middle Wesley Last Sisco				4. DATE OF DEATH Month June Day 16 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rock Hall, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Wesley Sisco				14. MOTHER'S MAIDEN NAME Ida Boyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mildred Harris- Pt's daughter - Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Miocardial insufficiency 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the lung? DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 7, 19 57 , to June 16, 19 57 , that I last saw the deceased alive on June 16, 19 57 , and that death occurred at 5:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 6-16-57 ACTUAL SIGNATURE T.F. Vestal M.D. Henryton, Maryland PHYSICIAN'S NAME (Type) Dr. Tom F. Vestal, Supt. Henryton State Hospital, Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-16-57		22c. NAME OF CEMETERY OR CREMATORY Sharptown	
22d. LOCATION (City, town, or county) (State) Sharptown Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Kermit Wesley				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE 6-16-57	
24b. REGISTRAR'S SIGNATURE Albert R. Anthon							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
March 20, 1957		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Hospital or Institution		County		State	
St. Mary's Hospital		Baltimore		Maryland	
Physician's Name		Physician's Address		Physician's Phone	
Dr. J. Smith		123 Main St.		555-1234	
Registrar's Name		Registrar's Address		Registrar's Phone	
Mr. J. Doe		456 Oak St.		555-5678	
Coroner's Name		Coroner's Address		Coroner's Phone	
Mr. J. Doe		789 Pine St.		555-9012	

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JUN 18 1957
BUREAU V. E.

6195

CERTIFICATE OF DEATH

Reg. Dist. No.

06789

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Upper Beckleysville Rd</u>				d. STREET ADDRESS <u>Upper Beckleysville Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Edward</u> Last <u>Tracey</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1910</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Edward Tracey</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Frances Hale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-18-5782</u>		17. INFORMANT <u>Mrs Frankie Tracey, Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rt Parotid Gland</u> <u>142.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 Months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Mar 22, 1956</u> to <u>June 21, 1957</u> that I last saw the deceased alive on <u>June 21, 1957</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hampstead, Md</u> DATE SIGNED <u>6/21/57</u> ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> <u>Hampstead Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR GREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 24/57</u>		<u>Mr Zion</u>		<u>Balto Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Epton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>6/21/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Henry Lewis</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

JUN 25 1957

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